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(2) The physician or optometrist actually performing, or exercising a direct personal supervision of the performance of the service, is participating in the Physician or Optical Care Program and is identified on each line item of service representing a professional service for which they are responsible by their provider identification number. (This item applies to all clinic provider types except Public Health Department Clinics, those Independent Clinics having an Ambulatory Surgical Care Type of Service designation and Adult Day Health Care centers.)

Clinic services are payable in accordance with all guidelines, restrictions, and limitation of Physicians' Services for all the clinic provider types except Professional Clinic Optometry which is the same as Optometrists Services, those Independent Clinics having an Ambulatory Surgical Care Type of Service designation and Adult Day Health Care Centers. Ambulatory Surgical Care covered services are those specifically listed surgical procedures and relatedancillaries which are provided in accordance with A.S.C. guidelines. Obstetrical delivery services are not included. Prior Authorization is required for the surgical procedures of Blepharoplasty and Excision of Keloids when performed in an Ambulatory Surgical Care Clinic. Adult Day Health Care services are provided in accordance with State Regulation 13 CSR 70-92.010 and subject to limitations as specified therein.

The global prenatal benefit covers all prenatal visits, routine urinalysis testing and pregnancy related conditions during the recipient's pregnancy period. Coverage of this benefit requires a minimum of five prenatal visits be provided and will be limited to one global service per pregnancy.

Coverage for clinical services related to the performance of certain specified elective surgical procedures requires the recipient obtain a documented medical second opinion. Coverage is provided for a documented third opinion, at the recipient's choice, when the second opinion fails to confirm the surgery recommendation of the first opinion.

Bone marrow, heart, kidney, liver, lung and certain restricted multiple organ transplants and related transplantation services are covered when prior authorized. Corneal transplants are covered without a requirement of prior authorization.

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10. Dental Services

Dental services as medically indicated are covered for, but not limited to: restorations (limited to silicate cement, amalgam, acrylic or composite filling); extractions; surgical prophylaxis (limited to one in a six-month period); fixed permanent crowns (limited to resin, stainless steel for all recipients; porcelain, high noble metal, noble metal limited to recipients under 21 years old with prior authorization); oral examinations (limited to three in a twelve-month period in a nursing home); and permanent full or partial dentures. Fluoride treatments are a covered service for all recipients. However, fluoride treatments for recipients age twenty-one (21) and over are limited to certain conditions. Date of service is date services are received or date of placement in case of dentures, full or partial.

All dentures, including full and partial, initial or replacement, require Prior Authorization be secured before the service is provided.

All full dentures and certain partial dentures are covered. Orthodontic services, specific tests, laboratory procedures, bridges and certain overdentures are covered services only for recipients under 21 years old when prior authorized.

11.a.,b.,c. Physical Therapy and Related Services

Physical therapy, occupational therapy, and speech, language or hearing pathology or disorders are not provided and reimbursed as separate, independent practitioner services.

Drugs

Effective January 1, 1991, the Missouri Medicaid Program covers outpatient drugs, in accordance with Sections 1902(a)(54) and 1927 of the Social Security Act, which are covered by a national or State agreement, with the following restrictions or exceptions (as indicated by checkmark).

__X__ A. Prior authorization program which complies with Section 1927(d)(5) of the Social Security Act.

__X__ B. The following drugs are covered, or restricted, as indicated by the checkmark:

__X__ 1. Certain drugs are not covered if the prescribed use is not for medically accepted indication, as defined by Section 1927(k)(6).

_____ 2. Drugs subject to restrictions pursuant to an agreement between a manufacturer and this State authorized by the Secretary under 1927(a)(1) or 1927(a)(4).

__X__ C. The following drugs or classes of drugs, or their medical uses, as indicated by a checkmark, are excluded from coverage or otherwise restricted:

__X__ 1. Agents when used for anorexia or weight gain.

__X__ 2. Agents when used to promote fertility.

__X__ 3. Agents when used for cosmetic purposes or hair growth.

_____ 4. Agents when used for symptomatic relief of cough and colds

__X__ 5. Agents used to promote smoking cessation.

_____ 6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

__X__ 7. Nonprescription drugs (see attached).

_____ 8. Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or his designee.

__X__ 9. Drugs described in section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations (DESI drugs).

__X__ 10. Barbiturates (see attached).

__X__ 11. Benzodiazepines (see attached).

State Plan TN# 96-21
Supersedes TN# 92-34

Approval Date JAN 23 1997
Effective Date December 1, 1996

EXCLUDED DRUG OR CATEGORY	EXCEPTIONS REIMBURSABLE
Drugs used to promote fertility	
Drugs used to promote weight loss	
Drugs used to promote hair growth	
Drugs used for cosmetic purposes	
Nonlegend vitamins, multi-vitamins and minerals, adult	Children's Chewable multi-vitamins, calcium preparations, iron preparations
Drugs used to promote smoking cessation	
Nonlegend lotions, shampoos, and medicated soaps	
Nonlegend acne preparations	
Nonlegend weight control preparations	
Nonlegend ophthalmic preparations	Artificial tear products, eyewash products, ocular lubricants
Contact lens products	
Nonlegend oral analgesics	All nonlegend strengths of: Acetaminophen, Aspirin, Buffered Aspirin, Ibuprofen
Nonlegend external analgesic products	
Nonlegend stimulant products	
Nonlegend hemorrhoidal products	
Estazolam	
Halazepam	
Prazepam	
Quazepam	

State Plan TN# 96-21
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PRIOR AUTHORIZED PRODUCT OR CATEGORY	ALLOWED INDICATIONS	EXCEPTIONS - PRIOR AUTHORIZATION NOT REQUIRED
Amphetamines	Attention deficit hyperactivity disorder, Narcolepsy	
Barbiturates	All medically accepted uses	Phenobarbital Methabarbital
Isotretinoin	Non-cosmetic uses	
Ketorolac, oral	All medically accepted uses within medically accepted dosage guidelines	Claims for no greater than a four (4) day supply of no greater than 40mg per day in any 30 day period.
Retinoic Acid	Non-cosmetic uses	
Sildenafil Citrate	Erectile dysfunction	

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Due to the complexity of the implementation of OBRA 90 pharmacy provisions, the limitation to five filled or refilled prescriptions per individual within each monthly period of recipient eligibility is suspended.

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12.b. Dentures

All dentures, including full and partial, immediate or replacement, require Prior Authorization be secured before the service is provided.

Replacement dentures will be approved in cases where the dentures no longer fit properly due to significant weight loss as a result of illness or a loss of bone or tissue due to some form of neoplasm and/or surgical procedure. Dentures will also be approved when the dentures no longer fit or function properly due to normal wear and/or deterioration resulting from use over an extended period of time.

A denture reline is covered during the 12 month period following the immediate placement of dentures. When necessary, another reline is covered after twelve (12) months following the placement of immediate dentures. Denture relines and denture rebases are not covered within twelve (12) months of placement of replacement dentures. Denture reline and denture rebase are further limited to once within three (3) years of the date of the last preceding reline or rebase.

12.c. Prosthetic Devices

Prosthetic and orthotic devices, non-sterile ostomy supplies, oxygen, respiratory equipment, wheelchairs, hospital beds, Home Parenteral Nutrition and related supplies, and medically necessary items of miscellaneous durable medical equipment are covered and provided through the Missouri Medicaid Durable Medical Equipment Program.

Prior authorization is required for certain orthotic and prosthetic devices, as well as the purchase and/or rental of al HPN services, electric wheelchairs, custom wheelchairs, electric hospital beds and back-up ventilators.

An Oxygen and Respiratory Equipment Medical Justification (OREMJ) form is required for the purchase and/or rental of most oxygen and respiratory equipment services.

A Medical Necessity form is required for the majority of orthotic and prosthetic devices. The form is also required for all wheelchairs other than electric or custom, manual hospital beds, and miscellaneous items of durable medical equipment such as walkers, crutches and commodes.

Hearing aids and related services are covered through the Hearing Aid Program. Prior to the dispensing of an aid, all recipients are required to have a medical ear examination for pathology or disease by a physician to determine if the recipient is a candidate for an aid. Hearing aids and related testing procedures are limited to one series every four (4) years. However, exceptions may be made if prior authorized for the following:

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12.c. Prosthetic Devices (Cont.)

(1) earmold replacements due to the growth of a child;
(2) replacement of a hearing aid within four (4) years from date of purchase due to loss, destruction, or if the aid ceased to function properly if prior authorized;
(3) binaural hearing aids if prescribed by an ear specialist and prior authorized.

Performance of the testing is limited to licensed hearing aid dealers, audiologists or physicians. Hearing aids can be dispensed by a physician, audiologist or hearing aid dealer, if the provider is licensed to dispense hearing aids and is enrolled as a hearing aid dealer/fitter or audiologist in the Medicaid Program.

All hearing aids and related services require prior authorization with the exception of audiometric testing that is not performed in a nursing home, post fitting evaluations, post fitting adjustments, repairs to hearing aids no longer under warranty, and replacement earmolds due to the growth of a child.

Approval for hearing aids for recipients in a nursing home requires the signatures of the nursing home administrator, the recipient, and the recipient's attending physician to be present on the Report of Hearing Aid Evaluation. A copy of the report must be attached to the claim for payment.

Post-fitting hearing aid adjustments and hearing aid repairs are limited to a combined total of three (3) services in any combination per year, per recipient.

All repairs for hearing aids must include a six- (6) month warranty. New hearing aids will not be purchased within six (6) months of the repair of an old hearing aid.

Hearing aid batteries, eyeglass hearing aid models, loaner or rented hearing aids, replacing batteries, deodorizing hearing aids, repairs to a hearing aid five (5) years of age or older are not covered.

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12.d. Eyeglasses

Eyeglasses can be dispensed by physicians, optometrists, or opticians. A maximum of one pair of eyeglasses is allowed every two (2) years (within a 24-month period of time) for all Medicaid recipients regardless of age. Eyeglasses are covered only when the prescription is at least 0.75 diopters for one eye or 0.75 diopters for each eye.

Supportive documentation of medical necessity is required for the repair of frames or replacement of parts of frames. Replacement of lenses covered within 24 months of Medicaid eyeglasses only when supported by Medical Necessity and prescription for change of 0.50 diopters for at least one eye.

13.d. Rehabilitative Services

Physical therapy and related services are covered services under the Missouri Medicaid Rehabilitation Program but are limited to the adaptive training of recipients receiving prosthetic/orthotic devices (artificial arms, artificial legs, artificial larynx, orthotics). These same services are also covered under the Home Health Program. (See item 7.d.)

The physical therapy services are restricted to:

(1) stump conditioning, wrapping, and exercising

(2) gait training or training in the use of a prosthesis or orthotic appliance for an extremity.

Occupational therapy is restricted to patient adjustment to the loss of a limb or use of a prosthesis or orthotic appliance for an extremity.

Speech therapy is restricted to a patient with loss of the larynx.

Community Psychiatric Rehabilitation Services:

Intake/annual evaluation, psychosocial rehabilitation, crisis intervention, community support, intensive community support, medication administration and medication services are covered for recipients under the Missouri Medicaid Community Psychiatric Rehabilitation Services Program. Services are designed to maintain seriously mentally ill recipients within the community at a level of care less restrictive than an inpatient psychiatric hospital or nursing facility.

These services are restricted to recipients who, through a medical evaluative and assessment process are found to be seriously and persistently mentally ill. Continuation of provision of services is conditional upon periodic review by a medical/clinical review team and physician recertification of the individual's treatment plan.

Substitute per letter dated 09/03/98

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Service provision is limited to providers approved by the Department of Social Services as meeting the Department of Mental Health certification standards for Community Psychiatric Rehabilitation Centers in state rules 9 CSR 30-4.030 through 9 CSR 30-4.047, and as possessing the ability to deliver the core program services.

A provider not meeting the certification standards in state rules 9 CSR 30-40.030 through 9 CSR 30-40.047, but authorized to provide services to children under the authority of Chapter 207 RSMo, may provide Comprehensive Community Support to children (under age 18 at the time of admission to the CPR program) who are found to have behavioral conditions, determined as described below, which require rehabilitative services at a residential treatment or specialized foster care level of care as described in 13 CSR 40-71.010 through 40-71.140 and 13 CSR 40-73.010 through 13 CSR 40-73.080 respectively, or who are being discharged from these two treatment levels, and who require Comprehensive Community Support in order to maintain the rehabilitation treatment outcome in a less restrictive environment. The Department of Social Services shall prior authorize the service and determine whether behavioral conditions warrant the provision of comprehensive community support through application of the screening tool known as Childhood Severity of Psychiatric (CSP) illness and a determination by the Department that comprehensive community support is medically necessary and appropriate to achieve or maintain achievement of the rehabilitative outcomes.

Comprehensive Community Support:

Comprehensive Community Support Services include any medical or remedial service reasonable and necessary for maximum reduction of a behavioral disability and restoration of the child to his or her best possible functional level. Examples include, but are not limited to:

- Intake, Assessment, Evaluation and Treatment Planning:
  - Psychosocial/clinical assessment to evaluate the child's presenting conditions and determine the rehabilitative treatment plans and services.
- Community Support
  - Ongoing assessing of the child's status including strengths, progress, problems and needs;
  - Participating in the planning or revision of an individualized treatment and rehabilitation plan;
  - Providing individualized interventions with the child and his or her caregivers to enable the child to acquire, transfer or generalize skills necessary to be successful in normalized living, learning, working and social environments;
  - Providing age-appropriate in-vivo training and assistance in daily living skills as may be necessary to be successful in normalized living, learning, working and social environments;